2018

Pinal County Employee Benefit Guide

PINAL COUNTY

Enriching Lives Beyond Expectation

Choosing your 2018-19 Benefits

Pinal County understands the importance of employee benefits and offers a comprehensive benefit package to protect employees and their families. We encourage you to carefully review this document and educate yourself about your options to choose the best coverage for you and your family.

Pinal County is pleased to provide the following benefits effective July 01, 2018:

- Health Care Plans – The County will be providing three Medical/Rx programs, Dental and Vision benefits through the Arizona Metropolitan Trust (AzMT).
- Life Insurance Benefits – Group Life and AD&D, Voluntary Life and Voluntary AD&D benefits through Securian.
- Employee Assistance Program (EAP) – Offering employees and household members valuable, confidential counseling and work-life services through Supportlinc.
- Wellness Program – Through AzMT L.I.V.E. we work to improve the quality of life and health status for all covered plan members.
- Flexible Spending Account – For healthcare and/or dependent daycare.
- Health Savings Account (HSA) – For members who enroll in the High Deductible Health Plan (HDHP), an HSA is a type of personal savings account that can be used to pay for qualified medical expenses on a pre-tax basis.
- Short-Term Disability – A County paid benefit for all benefit eligible employees. Provides up to six months of income replacement.
- Optional Benefits – Including a 457b Deferred Compensation Plan through Nationwide (available at any time during your employment).
- Statutory Benefits – Employees will automatically be enrolled in the applicable State Retirement System: Arizona State or Public Safety Personnel Retirement Corporation to include ASRS, PSPRS, CORP and EORP.

The purpose of this guide is to highlight your benefits; it does NOT replace your Summary Plan Documents. The information has been compiled into a summary to outline the benefits offered by Pinal County.

If this benefit guide does not address your specific benefit question, please refer to the contact information listed on the last page of this guide. This page will provide you with information you need to contact specific vendors for additional assistance.

The information provided is intended only as an overview of your benefits. Complete details about the benefit options are included in the Summary Plan Document and other plan documents. If there are discrepancies between this and the plan documents, the plan documents will govern. This benefit guide does not constitute a contract.

Terms You Should Understand While Reviewing this Guide

Accidental Death & Dismemberment (AD&D) – A type of life insurance policy that provides benefits to beneficiaries in the event of a loss due to accidental death or dismemberment.

Coinsurance – The division of the allowed amount to be paid by the benefit plan and the patient. For example 80/20 means the plan will pay 80% of the allowed amount and the patient is responsible for 20% (after the deductible has been satisfied).

Copayment – Fixed fees as shown in the medical benefit summary which generally are paid to the provider at the time services are provided.

Days – Calendar days; not 24 hour periods unless otherwise noted.

Deductible – Depending upon the plan in which you enroll, you may have to pay 100% of certain covered medical expenses each plan year, up to a dollar limit. This limit is called a deductible. All plans have individual and family deductibles.

Dependent – An individual in the employee's family who is enrolled as a covered participant under the Plan. Your dependent must meet the dependent eligibility requirements to be eligible.

Employee Assistance Program (EAP) – Designed to provide professional guidance to all employees and their dependents concerning issues such as work/life balance.

Exclusive Provider Organization (EPO) – A network of medical providers or groups of medical care providers, who have entered into written agreements with an insurer to provide health insurance to participants. All plans share the same network, BlueCross BlueShield of Arizona (BCBSAZ). The EPO has no out-of-network benefits.

Flexible Spending Accounts (FSA) – Enables participants to pay for certain healthcare and/or dependent care expenses on a pre-tax basis.

High Deductible Health Plans (HDHP) – A health insurance plan with lower premiums and higher deductibles. The HDHP has out-of-network benefits within Arizona and nationwide; however, participants can save money by taking advantage of the discounted rates and richer benefits with in-network providers in Arizona.

Health Savings Account (HSA) – Enables participants to set aside money on a pre-tax basis to pay for qualified expenses. HSA funds belong to the member, roll over from year to year and are not subject to use it or lose it provisions.

Open Enrollment Period – The period of time established by the County as the time when Participants and their Dependents may enroll for coverage. The Open Enrollment Period occurs at least once every Plan Year.

Out-of-Pocket Maximum – To protect you and your family from catastrophic medical expenses, all plans have limits on how much you pay out of your pocket for covered medical services in a year. This is called an out-of-pocket maximum. Once the coinsurance amounts and copays you pay for covered expenses (including prescriptions) reach the individual/family out-of-pocket maximum, the plans will cover 100% of the remaining covered expenses you or your family incurs for that plan year. There are separate out-of-pocket maximums for in-network and out-of-network benefits.

Plan Year – The 12-month period beginning at 12:01 a.m. on July 1 and ending 12:00 a.m. on June 30.

Preferred Provider Organization (PPO) – A network of medical providers or groups of medical care providers who have entered into a written agreement with an insurer to provide health insurance to participants. The PPO has out-of-network benefits within Arizona and nationwide; however, participants can save money by taking advantage of the discounted rates and richer benefits with in-network providers in Arizona.

Pre-Tax Deductions – The deductions taken from your paycheck for the benefits you select before federal, state and FICA taxes are calculated. Therefore, your taxable income is lower and you pay fewer income taxes.

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About this Guide

This benefit guide is a compilation guide of employee benefits. It is intended for informational purposes only. The actual benefits available and the full descriptions of these benefits are governed in all cases by the relevant plan document(s), insurance contracts, and Ordinances and Resolutions of Pinal County. If there are discrepancies between the benefit guide and the actual plan documents, insurance contracts, and Ordinances and Resolutions, the documents, contracts, and Ordinances and Resolutions will govern.

HIPAA Compliance

The Health Insurance Portability and Accountability Act (HIPAA) requires that your health insurance plan limit the release of your health information to the minimum necessary required for your care. If you have questions about your claims, contact your insurance carrier first. If, after contacting the Plan administrator, you need a representative of the Employee Benefits Department to assist you with any claim issues, you may be required to provide written authorization to release information related to your claim. If you would like a copy of the HIPAA Notice of Privacy Practices or if you have any questions, contact Human Resources at 520-866-6231.

2018 BENEFITS ENROLLMENT

Annual Enrollment
How to Enroll

Your Annual Enrollment

Important Dates to Remember

Your Open Enrollment Dates are:

April 9th - April 27th

Your Plan Year is:

July 1, 2018 - June 30, 2019

Note: Changes to insurance plans will go into effect July 1st.

Annual Open Enrollment

Each year Open Enrollment provides you an opportunity to change plans and modify dependent coverage. Your election deductions begin in June and will remain in effect through the plan year July 1, 2018- June 30, 2019 for your Voluntary benefits.

EVERY employee must complete a new enrollment for 2018-2019.

This is the one time each year that you can make changes to your benefit options, terminate coverage, drop or add a dependent without a qualifying life event. Dependent(s) Include:

SPOUSE

Definition: A person to whom you are in a legally valid, existing marriage.

Required Documentation:

- Copy of the Marriage Certificate.

CHILDREN

Definition: An employee's children or those of his/her legal spouse, including biological children, step-children, children under legal guardianship substantiated by a court order, legally adopted children and children placed for adoption in accordance with applicable State or Federal law.

A dependent child will be eligible for applicable benefits until the end of the month on his/her twenty-sixth (26th) birthday. A dependent child who is continuously incapable of self-sustaining employment because of a mental or physical handicap and who is chiefly dependent upon the employee for support may be eligible for benefits beyond the limiting age provided medical documentation is submitted within 31 days of the child reaching the limiting age or upon request by the insurance plan provider.

Required Documentation:

Natural child

- Copy of the child's birth certificate showing the name of the employee as a parent.

Step-child

- Copy of the child's birth certificate showing the name of the employee's spouse as a parent and a copy of the marriage certificate showing the names of the employee and spouse.

Permanent Legal Guardian or Adoption

- Copy of signed and file stamped court order providing employee or eligible spouse with legal custody.

The benefits you elect during open enrollment are for the fiscal plan year July 01, 2018 through June 30, 2019 (unless you experience a qualifying life event). **If you fail to complete a new enrollment form by May 1, 2018, you will be automatically enrolled in the PPO Employee Only Medical Plan effective July 01, 2018.**

If you experience a qualifying life event, you have 31 days from the date of that event to make a change and the benefit change must be consistent with the qualifying event.

Some examples of an allowable change event include:

- Change in legal marital status
- Termination or commencement of employment
- Change in the number of dependents

Please contact Human Resources for the required forms.
Please refer to the Summary Plan Document for a complete list of eligible/ineligible dependent and eligibility requirements.

Important Points To Consider

Before you meet with your American Fidelity Representative, take time to evaluate your current coverage and decide how well it serves the needs of you and your family

- Verify your dependents name matches what is on their Social Security Card
- Verify the Social Security Number is correct for all dependents
- Review your beneficiaries
- Determine an estimate of child care expenses
- Review American Fidelity's options of portable insurance plans that you can keep if your employment changes
- Evaluate your need for life insurance

How to Enroll

Pinal County is providing every employee with an opportunity to understand their employee benefits, ask questions unique to their situation, and enroll in benefits. These include:

- **One-on-One: In-Person**
- **Self-Enroll: Online**

Enroll On-site / One-on-one Benefit Review

On-site enrollment counselors will be available to assist you with the enrollment process. This provides you with the opportunity to ask unique questions regarding your benefit options, in a confidential and private setting.

Self-Enrollment: Online

Through AFenroll®, you can enroll through our secure online system that is accessible from any desktop browser. The site also contains educational benefit and enrollment preparation videos to answer any questions you may have.

AFenroll® Instructions

How to Login

1. To access the online enrollment site, go to **www.afenroll.com/enroll**
2. At the login screen, you will enter the site using the following information:
   - **Type in your user ID:**
     Your Social Security Number (SSN)
   - **Type in your PIN:**
     Your DOB in a mmddyy format. (For example, your birth date is January 29th, 1978, you would type in 012978).
3. Click the '**Log On**' button.

Changing Your PIN

You will be asked to change your PIN and complete the security questions, after your initial login to the system. Enter a new PIN and confirm it on the next line. You may choose any combination of letters and numbers. Entering your PIN is the equivalent of your digital signature. Before you can complete your PIN change, you must select a security question, answer it, and provide your email address. This will allow you to reset your PIN if you forget it. Click the 'Save New PIN' button

During your One-on-one Benefit Review, you can learn more about or enroll in the following:

- Medical Insurance
- Group Life Insurance
- Dental Insurance
- Vision Insurance
- Accident Only Insurance
- GAP Choice
- Cancer Insurance
- Group Critical Illness
- Flexible Spending Accounts
- Health Savings Account

Please note that when electing the American Fidelity Lump Sum Cancer Diagnosis Benefit or Group Critical Illness benefit, premiums will be deducted on a post-tax basis to avoid taxes being charged on the benefits you receive when submitting a claim.

Helpful Tips

- **Log Out**
  If you leave the site in the middle of the process, click the 'Log Out' button to save your selections.
- **Print Confirmation**
  Be sure to print your confirmation. Once you confirm your enrollment, you may click on the confirmation link at the bottom of the 'Sign/Submit Complete' to print your confirmation statement.
- **Re-Enter/Make Changes**
  You may re-enter the enrollment site (including to 'View Only' your original selections) to make changes at any time during your enrollment period. Please note: Before you exit the system, you must re-confirm with your PIN or your enrollment or changes will not be valid.
- **Opting Out (Waiving Coverage)**
  If you choose not to select benefits, you must enter each product module and make that choice.
- **Required**
  Social Security Numbers and Dates of Birth are required for all employees and their dependents.
- **Adding Dependent**
  If you are adding a dependent as a beneficiary, their Social Security Number is required.
- **PIN**
  Your PIN is your electronic signature. You will use your PIN to confirm applications and your enrollment confirmation.

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INSURANCE PLANS

- Health Plan Options
- Dental Plans
- Vision Plans
- County Paid Benefits
- Voluntary Benefits
- Supplemental Life
- Health Savings Accounts (HSAs)
- Flexible Spending Accounts (FSAs)
- Accident Insurance
- Cancer Insurance
- Group Critical Illness Insurance
- Hospital GAP PLAN Choice Insurance
- County Paid Benefits
- 2018-2019 Benefit Changes

Health Plan Options

Medical/Prescription Plan Options

Effective July 01, 2018 Pinal County will continue to offer three medical plan options:

- High Deductible Health Plan (HDHP)
- Preferred Provider Organization (PPO) Plan
- Exclusive Provider Organization (EPO) Plan

All plans utilize the BlueCross BlueShield of Arizona (BCBSAZ) network. BCBSAZ offers one of the largest networks of physicians, specialists and hospitals in Arizona. Provider's must be on the BCBSAZ network to be considered "in-network." Please refer to www.azblue.com/CHSNetwork to see if your doctor, and/or facility is a "contracted" provider prior to your next appointment.

HDHP Plan

The HDHP plan offers comprehensive medical coverage with the ability to receive care from any provider, both in and out-of-network. However, when you utilize an in-network provider, services provided are at negotiated rates and out of pocket expenses will be less than those out-of-network. In-network providers are in Arizona only. With the HDHP plan you are responsible for paying for all medical costs up to your deducible prior to the plan helping with any associated costs. Upon reaching your deductible, all eligible medical costs are covered at 100%.

PPO Plan

With the PPO plan you have the ability to receive care from any provider since it provides in and out-of-network comprehensive medical coverage. However, when you utilize an in-network provider, services provided are at negotiated rates and out of pocket expenses will be less than those out-of-network. In-network providers are in Arizona only.

EPO Plan

Like the other plan options, the EPO plan provides comprehensive medical coverage; however, this plan is an in-network, in Arizona only option. When services are rendered outside of the network, you will be responsible for the entire bill, as the plan will not pick up any of the cost except in a life-threatening emergency.

Prescription Drug Program

Navitus Health Solutions

When you elect medical coverage, you are automatically enrolled to receive prescription drug benefits. Pharmacy network services are provided by Navitus Health Solutions.

Retail Program

You have access to a large national network of retail pharmacies where you can have your prescriptions filled for a 30-day supply of medication. The amount you will be required to pay for the cost of your medication will depend upon the level/tier the prescription falls under and the plan you are enrolled in. You can locate participating pharmacies and check the prescription level/tier any time at www.navitus.com.

90 Day Retail Program

Many members require maintenance medications for conditions such as diabetes, high blood pressure, asthma, etc. For these members, Navitus contracts with a robust network of pharmacies that offer up to a 90 day supply of maintenance medications at a discounted copayment.

Mail Order Program

Costco Mail Order Pharmacy also offers members a mail order program for filling maintenance medications. Members are able to receive a 90 day supply of medications mailed to their home for a reduced copayment.

Specialty Pharmacy

Members who have chronic illnesses and complex diseases that take specialty high-cost and injectable drugs are required to obtain their specialty medications through Lumicera. Lumicera provides high-touch patient care to assist patients in managing these complex disease states.

Vaccination Program

Navitus has partnered with pharmacies to provide immunizations for members. At participating pharmacies, your copay for vaccines will be $0; available vaccines include: Influenza, Pneumonia, Tetanus/Diphtheria, Hepatitis A, Hepatitis B, Meningitis, Shingles, MMR, HPV, Pertussis and Varicella. To see if your pharmacy is participating, contact Navitus Customer Care at 866.333.2757.

Prescription Schedule:

	HDHP	EPO & PPO		
		Preferred	Non Preferred	Non Contracted
30-Day Supply				
Tier 1	No Charge After Deductible is Met (Except for Certain Preventive Medications)	$10	$15	You Pay the Non-Preferred Copay + the Difference Between the Contracted and Non Contracted Pharmacy Cost
Tier 2		$30	$35	
Tier 3		$50	$55	
Specialty		20% Up to $200	N/A	
90-Day Supply				
Tier 1		$25	$30	
Tier 2		$75	$80	
Tier 3		$125	$130	

Medical / Rx Plan Comparison

AmeriBen

July 01, 2018 through June 30, 2019

	HDHP		PPO		EPO
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network
Plan Year Deductible					
Single	$2,600	$5,000	$100	$500	$250
Family	$5,200	$10,000	$400	$1,000	$500
Plan Year Out-of-Pocket Maximum[1]					
Single	$2,600	$10,000	$2,500	$5,000	$2,500
Family	$5,200	$20,000	$5,000	$10,000	$5,000
Allergy Serums and Injections If received during an office visit when a Physician is seen, the paid under the office visit benefit.	0%*	50%*	$0 Copay	50%*	$0 Copay
Allergy Testing and Treatment	0%*	50%*	20%*	50%*	10%*
Ambulance Services	0%*	50%*	20%*	20%*	10%*
Chemotherapy (Outpatient)	0%*	50%*	20%*	50%*	10%*
Chiropractic Care/Spinal Manipulation	0%*	50%*	$20 Copay	50%*	$15 Copay
Plan Year Maximum Benefit	30 Visits		30 Visits		30 Visits
Diagnostic Testing, X-Ray and Lab Services					
Free Standing Laboratory Facility	0%*	50%*	0%	50%*	0%
Free Standing Radiology Facility	0%*	50%*	20%*	50%*	10%*
All Other Location (except office visit)	0%*	50%*	20%*	50%*	10%*
Durable Medical Equipment (DME)	0%*	50%*	20%*	50%*	10%*
Emergency Room	0%*	50%*	$250 Copay plus 20%* Copay Waived if Admitted		$50 Copay plus 10%* Copay Waived if Admitted
Home Health Care	0%*	50%*	20%*	50%*	10%*
Plan Year Maximum Benefit	60 Visits		60 Visits		
Hospice Care	0%*	50%*	20%*	50%*	10%*
Lifetime Maximum Benefit	6 Months		6 Months		6 Months
Hospital Expenses or Long-Term Acute Care					
Facility/Hospital (facility charges)					
Inpatient/Outpatient	0%*	50%*	20%*	50%*	10%*
Maternity					
First Visit to Confirm Pregnancy					
Primary Care Physician	0%*	50%*	$20 Copay	50%*	$15 Copay
Specialist	0%*	50%*	$40 Copay	50%*	$30 Copay
Prenatal and Postnatal Care	0%*	50%*	20%*	50%*	10%*
Delivery Charges	0%*	50%*	20%*	50%*	10%*

[1] Please note that there is a separate maximum out-of-pocket limit for prescriptions

Medical / Rx Plan Comparison

AmeriBen

July 01, 2018 through June 30, 2019

	HDHP		PPO		EPO
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network ONLY
Mental Health and Substance Abuse Disorders					
Inpatient	0%*	50%*	20%*	50%*	10%*
Outpatient	0%*	50%*	$20 Copay	50%*	$15 Copay
Outpatient Therapies (e.g., physical, speech, occupational)	0%*	50%*	20%*	50%*	10%*
Plan Year Maximum Benefit	20 Visits		20 Visits		20 Visits
Physician's Services					
Office Visits					
Primary Care Physician	0%*	50%*	$20 Copay	50%*	$15 Copay
Specialist	0%*	50%*	$40 Copay	50%*	$30 Copay
Physician Office Surgery					
Primary Care Physician					
Surgery Costing under $500	0%*	50%*	$20 Copay	50%*	$15 Copay
Surgery Costing $500 or more	0%*	50%*	20%*	50%*	10%*
Specialist					
Surgery Costing under $500	0%*	50%*	$40 Copay	50%*	$30 Copay
Surgery Costing $500 or More	0%*	50%*	20%*	50%*	10%*
Preventive Services and Routine Care					
Preventive Services per Health Care Reform (PPACA) (Includes the office visit and any other eligible item or service billed and received at the same time as any preventive service)	0%; Deductible Waived	Not Covered	$0 Copay	Not Covered	$0 Copay
Preventive Care Not Covered Under the Preventive Services Benefit per Health Care Reform (PPACA)	0%; Deductible Waived	Not Covered	$0 Copay	Not Covered	$0 Copay
Plan Year Maximum Benefit	$500		$500		$500
Radiation Therapy (Outpatient)	0%*	50%*	20%*	50%*	10%*
Skilled Nursing Facility and Rehabilitation Facility	0%*	50%*	20%*	50%*	10%*
Plan Year Maximum Benefit	60 Days		60 Days		60 Days
Urgent Care Facility *Copay applies per visit regardless of what services are rendered.	0%*	50%*	$50 Copay	50%*	$50 Copay
All Other Eligible Medical Expenses	0%*	50%*	20%*	50%*	20%*

*Applies after deductible

Medical Benefit Costs
Monthly Premium for Benefit Employees

	County Contribution	County HSA Contribution	Employee Contribution	Per Paycheck
Medical	**HDHP Plan**			
EE+Single	$442.78	$22.91	-	-
EE+Spouse	$787.82	-	$79.54	$39.77
EE+Child(ren)	$736.14	-	$62.03	$31.02
EE+Family	$1,020.32	-	$158.36	$79.18
	PPO Plan			
EE+Single	$465.69	N/A	$22.11	$11.06
EE+Spouse	$787.82	N/A	$184.76	$92.38
EE+Child(ren)	$736.14	N/A	$158.94	$79.47
EE+Family	$1,020.32	N/A	$300.97	$150.49
	EPO Plan			
EE+Single	$465.69	N/A	$34.05	$17.03
EE+Spouse	$787.82	N/A	$210.01	$105.00
EE+Child(ren)	$736.14	N/A	$181.78	$90.89
EE+Family	$1,020.32	N/A	$337.01	$168.51

Dental Benefits – Delta Dental

Pinal County offers one dental plan with a maximum benefit of $2,000.
Dental benefits utilize Delta Dental of Arizona as the network and also to process claims.
Coverage available for Dependent children up to age 19.

Basic Plan

Benefits		
Individual Deductible per Calendar Year	$50	
Family Deductible Per Calendar Year	$150	
Percentage Payable	**PPO/Premier Dentist**	**Out-of-Network**
Routine/Preventive Care	100%	80%
Basic Services		
Fillings	80%	60%
Endodontics	80%	60%
Periodontics	80%	60%
Oral Surgery	80%	60%
Major Services		
Crowns/Onlays	50%	40%
Prosthodontic/Prosthetics	50%	40%
Implants	50%	40%
Orthodontics (Adult & Child)	50%	50%
Dental Benefit Maximums		
Maximum Payable per Calendar Year	$2,000 per person	
Lifetime Orthodontic Benefit	$2,000 per person	

Dental Benefits – Delta Dental

Pinal County offers a Buy Up plan with a maximum benefit of $4,000.
Dental benefits utilize Delta Dental of Arizona as the network and also to process claims.
Coverage available for Dependent children up to age 26.

Buy Up Plan

Benefits		
Individual Deductible per Calendar Year	$50	
Family Deductible Per Calendar Year	$150	
Percentage Payable	**PPO/Premier Dentist**	**Out-of-Network**
Routine/Preventive Care	100%	80%
Basic Services		
Fillings	80%*	60%*
Endodontics	80%*	60%*
Periodontics	80%*	60%*
Oral Surgery	80%*	60%*
Major Services		
Crowns/Onlays	50%*	40%*
Prosthodontic/Prosthetics	50%*	40%*
Implants	50%*	40%*
Orthodontics (Adult & Child)	50%	50%
Dental Benefit Maximums		
Maximum Payable per Calendar Year	$4,000 per person	
Lifetime Orthodontic Benefit	$2,000 per person	

2018-19 Dental Benefit Costs				
	Dental		Dental Buy-Up	
Coverage Tier	EE Cost Monthly	EE Cost Per Pay	EE Cost Monthly	EE Cost Per Pay
Employee Only	$35.94	$17.97	$37.21	$18.61
EE+Spouse	$69.07	$34.54	$71.64	$35.82
EE+Child(ren)	$77.30	$38.65	$84.11	$42.06
EE+Family	$113.92	$56.96	$124.10	$62.05

Vision Benefits – VSP Vision

Exams and materials are available every 12 months.
Coverage available for Dependent children up to age 19.

Basic Plan

Benefits	
Copay Eye Exam	$10
Copay Contact Lens Exam	$60 (Max)
Copay Eyeglasses	$20
Frame Allowance	$150
Costco Frame	$80
Contact Lenses (In Lieu of Lenses/Frames) per Year	$150

Please see the VSP Benefit Summary for detailed benefit information.

Vision Benefits – VSP Vision

Exams and materials are available every 12 months.
Coverage available for Dependent children up to age 26.

Buy Up Plan

Benefits	
Copay Eye Exam	$10
Copay Contact Lens Exam	$60 (Max)
Copay Eyeglasses	$10
Frame Allowance	$245 (Max)
Costco and Walmart Frame	$120
Contact Lenses (In Lieu of Lenses/Frames) per Year	$175

Please see the VSP Benefit Summary for detailed benefit information.

2018-19 Vision Benefit Costs				
	Vision		Vision Buy-Up	
Coverage Tier	EE Cost Monthly	EE Cost Per Pay	EE Cost Monthly	EE Cost Per Pay
Employee Only	$6.48	$3.24	$9.32	$4.66
EE+Spouse	$13.98	$6.99	$20.45	$10.23
EE+Child(ren)	$12.36	$6.18	$18.97	$9.49
EE+Family	$19.76	$9.88	$30.62	$15.31

In addition to the Medical/Rx coverage, benefit eligible employees will also receive the following benefits.

Wellness Program

The primary goal of the wellness program is a healthier employee and dependent population with corresponding management of medical and prescription claim costs. Early Detection, Lifestyle Modification and Disease Management are the types of programs offered through the AzMT L.I.V.E. wellness program. On-site screenings and other programs will be available throughout the year for your convenience.

Participation is key to a successful wellness program and the key to a better quality of life for those who participate. Take the time to check out the programs being offered to you and your dependents as AzMT participants. It is good for your health!

Employee Assistance Program

Professional help through your EAP is available for many other types of problems that may affect your quality of life.

You have access to the Employee Assistance Program (EAP). Under the EAP, you and your household members can speak with a counselor who can help with an assortment of life's matters, such as:

- Job Performance
- Marital Difficulties
- Family Issues
- Communication Skills
- Managing Depression and Anxiety
- Alcohol/Substance Abuse
- Child and Elder Care Resources
- Parenting Support
- Anger Management
- Legal and Financial Issues
- Grief and Bereavement
- Smoking Cessation
- Weight Loss
- Time Management
- Stress Management
- Personal Concerns
- Career Management
- Self-Improvement Plans

County Paid Benefits

Basic Life Insurance and Accidental Death & Dismemberment Insurance

Basic Life insurance is provided through **Securian** and helps provide financial protection by promising to pay a benefit in the event of an eligible member's covered death. Basic Accidental Death and Dismemberment (AD&D) insurance provides an additional amount in the event of a covered death or dismemberment resulting from an accident.

Your Basic Life coverage amount is $50,000. For a covered accidental loss of life, your Basic AD&D coverage amount is equal to your Basic Life coverage amount.

Basic Life and AD&D coverage amount reduces by 50% at the age of 75.

Other Basic Life Features and Services

- Accelerated Benefit
- Portability of Insurance Provision
- Repatriation Benefit
- Right to Convert Provision
- Standard Secure Access account payment option
- Travel Assistance
- Waiver of Premium

Other Basic AD&D Features

- Air Bag Benefit
- Family Benefits Package
- Seat Belt Benefit

Short-Term Disability Insurance

Benefit eligible employees will receive County paid Short-Term Disability Insurance (STD). The STD plan provides income replacement for a qualifying disability for up to six months. The plan has a 14-Day Elimination Period during which you must use your sick, vacation, and comp time accruals. The plan provides 60% income replacement. There is no minimum weekly benefit; however, the maximum weekly benefit is $1,900, based on your salary. You must use your sick accruals to make up the difference between the paid benefit and your actual salary.

Voluntary Benefits

Supplemental Life

Employees may elect supplemental life insurance in increments of $10,000 up to the lesser of 6 times your annual salary or $500,000. This does NOT include Basic Life.

Spouses can request in increments of $5,000 up to a maximum of $250,000. Spouse coverage cannot exceed 100% of Employee combined Basic and Supplemental Life.

Child(ren) coverage may be elected in increments of $2,500 up to a maximum of $10,000 The plan covers children up to age 26.

If you are an existing employee (not hired within the last 31 days), you have an annual open enrollment opportunity to increase your Supplemental Life by $10,000 without providing Evidence of Insurability (EOI) as long as your current coverage does not exceed the Guaranteed Issue (GI) amount of $150,000.

Should you wish to apply for Supplemental Life in excess of $10,000, you must complete the Evidence of Insurability (EOI) form and be approved through the carrier.

Any change to Spouse Supplemental coverage will require an Evidence of Insurability (EOI) form and be approved through the carrier.

Rates for Supplemental Life

Monthly Rates for Employee and Spouse Supplemental Life are per $1,000 of coverage:

	Employee	Spouse
<30	$0.060	$0.049
30-34	$0.080	$0.050
35-39	$0.090	$0.066
40-44	$0.124	$0.093
45-49	$0.201	$0.141
50-54	$0.307	$0.214
55-59	$0.496	$0.356
60-64	$0.660	$0.538
65-69	$1.270	$0.914
70-74	$2.060	$1.624
75*	$7.532	$3.340

*If you need rates for Age 76+, please see Human Resources.

Rates for Child(ren) are $0.13 per $1,000 of coverage. Monthly premiums per increment are:

$2,500	$0.325
$5,000	$0.65
$7,500	$0.98
$10,000	$1.30

Voluntary Accidental Death & Dismemberment (VAD&D)

If you are an active employee, you may elect Voluntary AD&D in $10,000 increments up to a maximum of $500,000. You have the option of electing Employee Only VAD&D coverage or Family VAD&D coverage.

If Family VAD&D coverage is elected, your eligible spouse and child(ren)'s coverage amounts will automatically be a percentage of the employee elected amount as follows:

- Spouse with no children – 50% of employee's VAD&D coverage amount;
- Child(ren) with no spouse – 15% of employee's VAD&D coverage amount; or
- Spouse and Child(ren) – 40% of employee's VAD&D coverage amount for the spouse and 10% of the employee's VAD&D coverage amount for each child.

Monthly VAD&D Employee Only rates are $0.03 per $1,000 of coverage and $0.045 per $1,000 of coverage for Family Coverage.

If your spouse or child is eligible for employee coverage under the County, they cannot be covered as a dependent. Only one employee may cover a dependent child.

At age 75 life insurance coverage will be reduced by 50%.

Health Savings Account (HSA)

Employees who select the HDHP medical plan will be automatically enrolled into a HSA.

A Health Savings Account (HSA) is a tax-free savings account that is combined with the HDHP medical plan. The HSA is different from an FSA because the money deposited into the HSA belongs to you, and you don't lose it if you don't spend it. You can use your HSA to pay for your insurance deductible and qualified out-of-pocket medical expenses.

Your contributions to your HSA are deducted from your paycheck in 24 equal increments over the plan year on a pre-tax basis, and contributions are available for use when deposited to your account. If a balance remains in your HSA at the plan year's end, all funds roll over for use during the next plan year. In addition, you accumulate tax-free interest on your HSA funds. Thus, you can use your account to save for care you may need in the future.

Please Note: The IRS limits the total amount that can be contributed to an HSA on an annual basis, those limits are:

Employee: $3,450
Family: $6,850

(If you are 55 or older, you can also make a $1,000 catch-up contribution)

Like a personal savings account, the money in an HSA rolls over annually, the funds never expire, and you can take it with you wherever you go, even if you leave your current employer.

Flexible Spending Accounts

American Fidelity Assurance Company

Flexible Spending Accounts are great cost savings tools to help with common medical expenses not covered by your major medical insurance and/or dependent care expenses. You can elect a portion of your pay to be deducted, on a pre-tax basis, from each paycheck to use for reimbursement of qualified out-of-pocket expenses throughout the plan year.

Flexible Spending Account Savings Example

With FSA		Without FSA
$30,000	Annual Gross Income	$30,000
- $2,400	Healthcare FSA Deposit	$0
- $2,500	Dependent Care Account Deposit	$0
$25,100	Taxable Gross Income	$30,000
- $5,020	Estimated Federal Tax (20%)	- 6,000
- $1,920.15	Estimated FICA (7.65%)	- 2,295
$18,159.85	Annual Net Income	$21,705
$0	Cost of Medical Expenses	- $2,400
$0	Cost of Dependent Care Expenses	- $2,500
$18,159.85	**Spendable Income**	**$16,805**
With an FSA, potential annual savings in this example is: $1,354.85		
By using an FSA to pay for eligible expenses, you can reduce your taxable income which will result in additional spendable income.		

Healthcare Flexible Spending Account (Healthcare FSA)

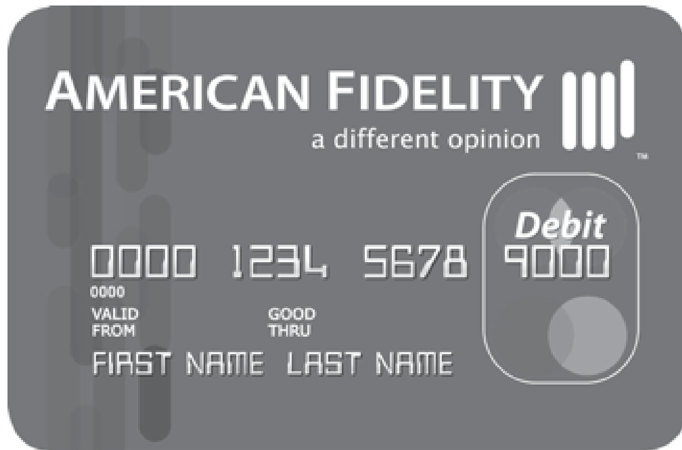
A Healthcare FSA allows you to allocate money on a pre-tax basis to reimburse yourself for qualified medical expenses for you and your family. Qualified expenses include anything from co-payments, medical deductibles, prescriptions and much more.

Maximum Annual Election: $2,650 per plan year

Examples of Eligible Expenses for Healthcare FSA
Copays/coinsurance
Deductibles
Dental treatments
Diabetic supplies
Prescription drugs and medicines
Eye exams, eyeglasses, contact lenses, contact lens solution and enzyme
Flu shots
Immunizations
Lab fees
Laser/Lasik/RK surgery
Medical exams
Orthodontia
Psychiatric care
Wheelchair
X-rays
For a more complete list of eligible expenses, please visit www.americanfidelity.com

Benefits Debit Card

American Fidelity will provide a Benefits Debit Card to all employees who elect to participate in a Healthcare FSA. The debit card gives immediate, convenient access to Healthcare FSA funds at the point of sale for prescriptions, copays, and other common qualified medical expenses. The card can only be used for the Healthcare FSA and is not available for the Dependent Care Account DCA.



Using Your Benefits Debit Card

Simply swipe your card like you would with any other credit card. Whether at the doctor's office or the dentist, the amount of your eligible expenses will be automatically deducted from your Healthcare FSA. Save ALL receipts!

Cards for Healthcare FSAs can be used at:

- Health care related facilities which include: hospitals, physician offices, dental offices, vision offices; and,
- Merchants participating in the Inventory Information Approval System (IIAS).
- The card is for medical expenses only; dependent day care expenses are not eligible.
- The card cannot be used for over-the-counter drugs filled with a prescription. You will need to file a manual claim for these types of expenses.

Snap. Submit. And Go!

When using your Benefits Debit Card to pay for an eligible expense, you may need to retain documentation to verify the expense. The AFreimburse app makes this easy.

- **Snap** a photo of the itemized receipt* with your phone.
- **Submit** the photo of the itemized receipts within the app when you receive notification that a receipt is needed to verify your expense.
- **Go**! After submitting your verification and its review, you will be able to view the status of your reimbursement within the app.

*The Internal Revenue Code (IRC) requires proof of the eligible expenses using itemized receipts or other documentation showing the date of service, person for whom service was provided and description of the expense. Depending on the type of expense, documentation may come in the form of third party itemized statements or Explanation of Benefits.

Activating Your Card

You will receive your card at your home address and may begin using your card on the first day of your plan year. Your card will be automatically activated when you use it for the first time for an eligible expense.

Dependent Care Account (DCA)

A Dependent Care Account allows you to allocate money on a pre-tax basis to reimburse yourself for dependent care expenses that allow you (and your spouse) to work. Reimbursement is permitted only after the services have been provided and the expense has been paid. As dependent care contributions are withheld from your paycheck and placed into the account, these funds become available for reimbursement requests. Submit the entire amount of your dependent care expense after the care is provided, even if it exceeds your monthly contribution amount, to maximize reimbursement opportunities. This allows you to build up a "pool" of submitted expenses, with pending amounts ready for reimbursement as soon as your next contribution is received and deposited into your account.

Maximum Annual Election: maximum annual election $5,000 per year (note: employees who are married but file their taxes separately, the maximum annual election combined cannot exceed $5,000).

Examples of Eligible Dependent Care Expenses
After-school care or extended day programs
Nanny expenses
Baby-sitter inside or outside participant's household
Custodial or elder care expenses if the qualifying individual still spends at least 8 hours each day in the employee's household
Dependent Day Care center* expenses/pre-kindergarten/nursery school expense
Expenses paid to a non-dependent relative of participant to care for the child
Summer day camp if the primary purpose of the expense is custodial in nature and not educational
For a more complete list of eligible expenses, please visit www.americanfidelity.com.
**A Dependent Care Center is a place that provides care for more than six persons (other than persons who live there) and receives a fee, payment or grant for providing services for any of those persons, regardless of whether the center is run for profit.*

Regardless of whether you participate in the Dependent Care Account under the Flexible Spending Account (FSA) or claim the Dependent Care credit on your income tax return, you must provide the Internal Revenue Service with the name, address and taxpayer identification number (TIN) or Social Security number of your dependent care provider(s) by completing either Schedule 2 of Form 1040A or Form 2441 and attaching it to your annual income tax return. Be sure that you follow the current instructions given by the IRS for preparing your annual income tax return. Failure to provide this information to the IRS could result in loss of the pre-tax treatment of your Dependent Day Care FSA contributions or loss of the Dependent Care Tax Credit.

FSA Fund Availability

Healthcare FSA

Your full annual election is available to you on the first day of the plan year.

Dependent Care Account

Unlike the Healthcare FSA, the entire elected amount is not available on the first day of the plan year, but rather as contributions are received.

Important FSA Notes:

- Participants are generally allowed a 90-day run-off period after the plan year ends in which to submit claims for expenses that occurred during the plan year but were not yet submitted.
- If you are a new employee entering the FSA Plan during a plan year, reimbursement is only available for expenses and services provided after you begin your participation in the FSA Plan.
- If you are enrolled in the Healthcare FSA and take a leave of absence during the plan year, you may (subject to your employer's plan):
  1. Prepay the contributions on a pre-tax basis, or
  2. Continue the contributions by remitting them to your employer. Pre-tax contributions may continue if you contiune to receive enough pay, or
  3. Prorate the unpaid contributions over the remaining pay periods when you return to work.
- Failure to make all elected contributions will result in termination of your account as of the date contributions ceased.
- Healthcare FSAs must comply with COBRA and generally must offer COBRA continuation rights to qualified beneficiaries who lose Healthcare FSA coverage due to certain qualifying events. For most Healthcare FSAs, COBRA may be offered upon a qualifying event only if you have a balance remaining in your Healthcare FSA. The balance is generally calculated by subtracting the reimbursements made prior to the qualifying event from the annual election. If eligible, you may choose to continue your contributions by either sending your contributions to your employer on an after-tax basis each pay period, or, you may choose to make a pre-tax contribution for your remaining elections for the plan year from your final pay or severance pay. Expenses incurred while contributions are being made are eligible for reimbursement. Coverage generally may not continue beyond the current plan year. If you do not elect COBRA, only expenses incurred during the period of employment are reimbursable. Coverage under the Healthcare FSA ceases when the contributions cease.

SB-23290-0917

File a Claim

Three Easy Ways

1. **On your mobile device using AFmobile or AFreimburse**

Use AFmobile to manage your insurance benefits. Use AFreimburse to manage your reimbursement accounts.

2. **Online at americanfidelity.com**

3. **By mail or fax**

Insurance Claim
American Fidelity Assurance Company, Attn: Benefits Department
P.O. Box 268898, Oklahoma City, OK 73125
Fax: 800-818-3453

FSA Claim
American Fidelity Assurance Company
Attn: Flex Account Administration
P.O. Box 161968, Altamonte Springs, FL 32716
Fax # 844-319-3668

*Obtain a claim form for your insurance claim at www.americanfidelity.com/fileaclaim.

Manage Your Reimbursement Account With AFreimburse™

American Fidelity is excited to introduce our mobile app, AFreimburse! AFreimburse allows FSA and HRA participants to submit reimbursement account claims while on the go.

- Access accounts - check balances, view transaction history, and more.
- Manage claims - submit new claims, upload receipts, and check claims status.
- Receive account alerts - choose to receive account updates by text and push notifications.
- Submit documentation - tie receipts and other documentation to a pending card swipe to expedite adjudication.

Download AFreimburse. To register, you will need:

- Your employee ID - for most participants this is your Social Security Number.
- A registration ID - which is your Benefits Debit Card number, or your employer ID number.

Using Our Online Portal

Our online portal provides all the same great features as mobile, plus powerful self-service account access and education resources to help put you in the driver's seat.

Getting started:

- Register at americanfidelity.com
- Register using your email address and Social Security Number
- Once completed, access your reimbursement accounts, insurance benefits.

Direct Deposit

By enrolling in direct deposit, you can ensure a timely reimbursement! You will no longer need to worry about having to wait on checks or make any more trips to the bank.

Three ways to sign up for direct deposit:

1. Through your mobile app.
2. Online through your account at americanfidelity.com
3. By downloading a direct deposit request form

SB-23290-0917

Accident Only Insurance

Limited Benefit Accident Only Insurance

American Fidelity Assurance Company

Whether a weekend warrior with an active lifestyle or just a busy family, accidents can happen anytime, anywhere, without warning. Being prepared for the unexpected can make all the difference.

American Fidelity's Accident Only Insurance policy provides you a solution for those unforeseen accidents that life sometimes delivers. Our Limited Benefit Accident Only Insurance is designed to help pay for the unexpected medical expenses an individual may incur for the treatment of covered injuries received in an accident.

How the Plan Works

Our Accident Only Insurance policy pays according to a wide-ranging schedule of benefits. In addition, the policy provides 24-hour coverage for accidents that occur both on and off the job.

All benefits are only paid as a result of Injuries received in an Accident that occurs while coverage is in force. All treatment, procedures, and medical equipment must be diagnosed, recommended and treated by a Physician. All benefits are paid once per Covered Person per Covered Accident unless otherwise specified in the Limitations and Exclusions section.

Optional Rider

Enhance your base plan with the following rider:

- **Accident Benefit Enhancement Rider**

Coverage Feature	What It Means For You
Plan Options: Basic, Enhanced, and Enhanced Plus	Choose the plan to meet your financial needs.
Four Choices of Coverage: Individual, Individual and Spouse, Individual and Child, or Family	Choose the coverage that fits your lifestyle.
Wide-Ranging Schedule of Benefits	Covers all types of covered injuries.
Wellness Benefit	The plan pays an annual Wellness Benefit for one Covered Person to receive a routine physical exam, including immunizations and preventative testing.
Accident Emergency Treatment Benefit	Receive a benefit when emergency treatment in a Physician's office or emergency room occurs within 72 hours of a covered accident.
Benefit Paid Directly to You, to use as you see fit	Use the benefit however best fits your financial needs.
Guaranteed Renewable	Keep your coverage as long as premiums are paid as required.
24-Hour Coverage	You are covered on or off the job.
Portable	You own the policy. Take the coverage with you if you choose to leave your current job. Your premiums will remain the same.
Additional Coverage Options	Enhance the base plan by adding an optional rider.
Payroll Deducted	Enjoy the convenience of having your premiums deducted straight from your paycheck.

Limitations, exclusions and waiting periods apply. Refer to your policy for complete details, AO-03 series with AMDI258 rider. **This product is inappropriate for people who are eligible for Medicaid coverage.** The premium and amount of benefits provided vary dependent upon the plan selected. The company has the right to change premiums by class. Availability of riders my vary by state.

SB-23288-0317

Cancer Insurance

Limited Benefit Cancer Insurance Policy

American Fidelity Assurance Company

A cancer diagnosis may be overwhelming. Even with a good medical plan, the out-of-pocket costs of cancer treatment, such as travel, childcare, and loss of income, are considerable and may not be covered.

American Fidelity Assurance Company's Cancer Insurance offers a solution to help you focus your attention on fighting cancer. We offer plans that can help assist with out-of-pocket costs often associated with a cancer diagnosis.

How the Plan Works

Our plan is designed to help cover expenses if you are diagnosed with a covered Cancer. With over 20 benefits available to you, this plan provides benefits for the treatment of cancer, transportation, hospitalization and more. We provide the benefit directly to you, to be used however you see fit.

Optional Riders

Enhance your base plan with the following riders:

- **Critical Illness Rider**
  Includes a cancer benefit and a heart attack/stroke benefit
- **Hospital Intensive Care Unit Rider**

Coverage Feature	What It Means For You
Plan Options: Basic, Enhanced and Enhanced Plus	Choose the plan to meet your financial needs.
Three Choices of Coverage: Individual, Single Parent Family, or Family	Choose the coverage that fits your lifestyle.
Wide-Ranging Schedule of Benefits	Covers a wide range of treatments.
Benefit Paid Directly to You	Use the money however best fits your financial needs.
Guaranteed Renewable	Policy is guaranteed renewable as long as premiums are paid as required.
Diagnostic and Prevention Benefit	Receive a benefit for visiting your doctor for a cancer screening test, which helps with early detection.
Transportation and Lodging	Receive benefits if you travel more than 50 miles from your home using the most direct route for covered treatment.
Portable	You own the policy. Take the coverage with you if you choose to leave your current job. Your premiums will remain the same.
Additional Coverage Options	Enhance the base plan by choosing from a selection of optional riders.
Payroll Deducted	Enjoy the convenience of having your premiums deducted straight from your paycheck.

Limitations, exclusions and waiting periods apply. Please refer to your policy for complete details. **This product is inappropriate for people who are eligible for Medicaid coverage**. The company has the right to change premiums by class. The premium and amount of benefits provided vary dependent upon the plan selected.

SB-23287-0317

Group Critical Illness Insurance

Limited Benefit Group Critical Illness Insurance Policy

American Fidelity Assurance Company

Surviving a critical illness, such as a heart attack or stroke, can come at a high price. With advances in technology to treat these diseases, the cost of treatment rises more and more every year. Even with medical insurance, the out-of-pocket expenses associated with a critical illness can affect anyone's finances.

American Fidelity Assurance Company's Limited Benefit Group Critical Illness Insurance can be the solution that helps you and your family focus on recovery, and may help you with paying bills. Our plan can assist with the expenses that may not be covered by major medical insurance.

How the Plan Works

If you are diagnosed with a covered Critical Illness, such as a heart attack or stroke, this plan is designed to pay a lump sum benefit amount to help cover expenses. Also, this plan offers a Recurrent Diagnosis Benefit for certain specified Critical Illnesses that provides an additional 50% of the Critical Illness benefit amount after the second occurrence date. Covered Critical Illness events include Heart Attack, Permanent Damage Due to a Stroke, and Major Organ Failure.

Guaranteed Renewable

You are guaranteed the right to renew your base policy until age 75 as long as you pay premiums when due or within the premium grace period. The insurer has the right to increase premium rates if the policy so provides.

Coverage Feature	What It Means For You
Plan Options	Choose from three lump sum benefit amounts: $10,000, $20,000 or $30,000.
Coverage Option	Children are automatically covered under the Employee base plan. If elected, Spousal Benefit Amounts will be 50% of the Employee Benefit Amount.
Wellness Benefit	Receive a benefit for your annual health screening test.
Benefit Paid Directly to You	Use the benefit however best fits your financial needs.
Portable	You own the policy. Take the coverage with you if you choose to leave your current job. Your premiums will remain the same.
Additional Coverage Options	Enhance the base plan by adding an optional rider.
Payroll Deducted	Enjoy the convenience of having your premiums deducted straight from your paycheck.

Limitations, exclusions and waiting periods apply. Please refer to your policy for complete details. **This product is inappropriate for people who are eligible for Medicaid coverage**. Group Critical Illness is only offered on an after-tax basis.

SB-30543-0317

Hospital GAP PLAN® Choice

Hospital Limited Benefit Medical Expense Insurance Policy

American Fidelity Assurance Company

Hospital GAP PLAN® Choice Insurance from American Fidelity Assurance Company can help policyholders pay for their out-of pocket expenses. Supplementing their medical insurance with gap insurance can help cover their expenses so they can focus on getting well.

Three Primary Benefits

- **In-Hospital****
- **Outpatient**
- **Physician Outpatient Treatment**

**"Hospital" shall not include any institution used as a place for rehabilitation, a place for rest or for the aged, a nursing or convalescent home, a long term nursing unit or geriatrics ward, or an extended care facility for the care of convalescent, rehabilitative or ambulatory patients.

Coverage Feature	What It Means for the Policyholder
In-Hospital Benefit	This is payable for covered for out-of-pocket expenses up to the maximum benefit selected per confinement.
Outpatient Benefit	The plan covers qualified out-of-pocket expenses for injury or sickness (depending upon the plan selected) up to a maximum outpatient benefit of: • $400, $800 or $1,200 for outpatient surgery or treatment performed in a Hospital or a Free-Standing Outpatient Surgery Center; • $100, $200 or $300 for outpatient diagnostic testing procedure performed in a hospital or a Free-Standing Magnetic Resonance Imaging (MRI) Facility.; or • $50, $100 or $150 for outpatient treatment in a Hospital Emergency Room, without the covered person subsequently being considered an inpatient.
Physician Outpatient Treatment Benefit	This is payable for Physician visits. This benefit pays up to $25.00 per visit, for up to five visits ($125.00) per family per calendar year, for outpatient treatment due to Sickness, or outpatient emergency care for an injury due to an Accident, provided the Covered Person is covered by Another Medical Plan when such charges are incurred, at a Hospital outpatient clinic, free-standing emergency care clinic, or Physician office for out-of-pocket Covered Charges.

THIS IS A LIMITED POLICY. This highlights the important features of the policy. Limitations, exclusions, and waiting periods apply. Refer to the policy for complete details. **This product is inappropriate for people who are eligible for Medicaid coverage**. If the policyholder resides in a state other than their employer's state of domicile, where required by law, policy provisions and benefits may vary.

ARIZONA METROPOLITAN TRUST (AzMT)

Benefit Changes 2018-2019

The following changes will be effective for AzMT benefit plans effective July 1, 2018

HDHP / PPO / EPO

- Updated coverage for revised preventice benefits under ACA

Teladoc

Speak to a licensed doctor by web, phone, or mobile app in minutes. Note: you must be enrolled in AzMT Medical coverage and be registered on the Teledoc website (https://www.teladoc.com/start/). Each employee will be given one free Teladoc visit.

Waiving Medical Coverage

Employees who elect not to enroll in medical coverage with Pinal County will be offered:

- Dental Buy-Up at no cost
- Vision Buy-Up at no cost
- Flexible Spending Account (FSA) For you and your qualified dependents

FSA maximum increased to $2,650

Important Information

When does benefit coverage end?

Coverage ends the last day of the month in which you are no longer an eligible employee. Following your termination, the COBRA Administrator (AmeriBen) will send you information regarding your rights to continue insurance coverage.

You are also responsible for notifying HR within 31 calendar days when a dependent is no longer an eligible dependent, e.g. child's dependent status due to age, etc.

What changes can I make during the plan year?

Generally, benefit elections made during Open Enrollment or when newly eligible are irrevocable during the plan year. However, when you have a qualified life event, you are permitted to make changes consistent with that life event. Qualified events include: marriage, divorce, legal separation, birth or adoption of a child, change in child's dependent status, death of spouse, child or other qualified dependent, change in residence due to an employment transfer for you or your spouse, commencement or termination of adoption proceedings, or change in spouse's benefits or employment status.

When are qualified life event changes effective?

Qualified life event changes are effective the first of the month following the event. The exception is employees adding a new dependent when the change becomes effective on the date of the event (date of birth, date of adoption) after timely submission of the request. Status changes may require a retroactive premium.

Are my deductibles plan year or calendar year?

All of the insurance plans offered through AzMT renew each fiscal year (plan year July-June) which means that all deductibles and out of pocket maximums are based on a July to June time frame.

Who do I call with questions about payment of my medical/dental/vision claims?

Contact AmeriBen at 855-350-8699 regarding the status of a claim. You can also sign on to https://www.myameriben.com to obtain information about your claim. Please refer to your summary plan document/benefit booklet for information regarding claim appeal procedures. If, after you have contacted AmeriBen, you still need assistance, please contact Human Resources at 520-866-6231.

What supporting document must I turn in? What if I have turned them in at previous enrollments?

If you have turned in supporting documents for your dependents at previous enrollments, you do not need to supply them again. Please verify your dependents' name, date of birth, and Social Security Numbers are correct. However, if you are enrolling a new dependent, you will be required to supply supporting documents.

Important Information

	Definition	Required Document(s)
Spouse	A person to whom you are in a legally valid, existing marriage.	• Copy of the Marriage Certificate.
Children	An employee's children or those of his/her legal spouse, including biological children, step-children, children under legal guardianship substantiated by a court order, legally adopted children and children placed for adoption in accordance with applicable State or Federal law. A dependent child will be eligible for benefits until the end of the month on his/her nineteenth (19th) or twenty-sixth (26th) birthday dependent on the plan. A dependent child who is continuously incapable of self-sustaining employment because of a mental or physical handicap and who is chiefly dependent upon the employee for support, may be eligible for benefits beyond the limiting age, provided medical documentation is submitted within 31 days of the child reaching the limiting age or upon request.	**Natural Child** • Copy of the child's birth certificate showing the name of the employee as a parent **Step-Child** • Copy of the child's birth certificate showing the name of the employee's spouse as a parent *and* a copy of the marriage certificate showing the names of the employee and the spouse **Permanent legal Guardian or Adoption** • Copy of signed and file-stamped court order providing employee or eligible spouse with legal custody

Remember

Open Enrollment begins April 9, 2018, and closes on April 27, 2018, benefit elections will not be accepted after April 30, 2018. This is intended as a reference only; please refer to your Summary Plan Document (found online at http://www.azmt.org/pinal-county) for more detailed coverage information.

Benefits Directory

Core Benefits

AmeriBen IEC/Group
Medical claims, coverage questions,
eligibility and ID cards.
855.350.8699
www.myameriben.com

Prescriptions
Navitus Health Solutions
Prescription claims and coverage questions.
866.333.2757
www.navitus.com

Costco Mail Order Pharmacy
800.607.6861
www.pharmacy.costco.com

Utilization Review
American Health Group
Precertification for medical necessity and
Case Management.
800.847.7605

Life and AD&D
Securian*
Life Insurance
800.392.7295
www.ochsinc.com

EAP
Alliance Work Partners
Confidential Counseling for life's matters.
800.343.3822
www.awpnow.com/main

Delta Dental of Arizona
Dental claims, coverage questions,
and eligibility.
800.352.6132
www.deltadentalaz.com

VSP Vision
Vision Claims, coverage questions
800-877-7195
www.vsp.com

Section 125 Administrative Services & Flexible Spending Accounts

American Fidelity Assurance Company
Attn: Flex Account Administration
P.O. Box 161968
Altamonte Springs, FL 32716
Fax # 844-319-3668
www.americanfidelity.com

Voluntary Benefits

American Fidelity Assurance Company
Accident, Cancer, Group Critical Illness and GAP PLAN
Mon - Fri, 7 a.m. - 7 p.m. CST
800-662-1113
www.americanfidelity.com

Other Contact Information

Pinal County
31 N. Pinal St., Building A
P.O. Box 1590
Florence, AZ 85132
Phone: 520-866-6231
Fax: 520-866-6930

*Note: Securian is administered by Ochs, Inc. who handles all administration of the Life benefit.

This Enrollment Benefits booklet is not a contract, is not legally binding, and does not alter any original plan documents. Rather, it is intended to be a summary of available benefits provided through your employer. Every effort has been made to ensure the accuracy of this information. However, the actual determination of your benefits is based solely on the plan documents and if statements in this description differ from the applicable plan documents, coverage documents or Summary Plan Descriptions, then the terms and conditions of those documents will prevail. Please check with your employer's Benefit's Office for further guidance.